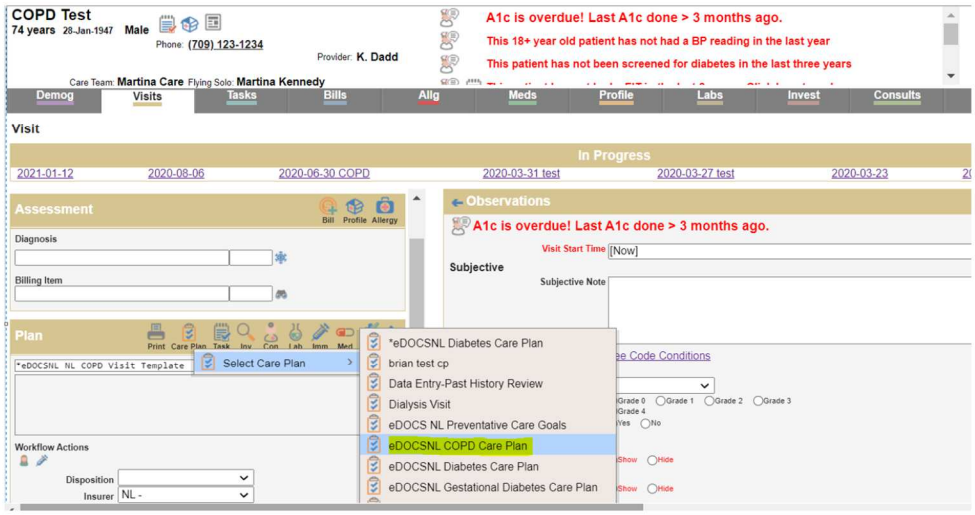
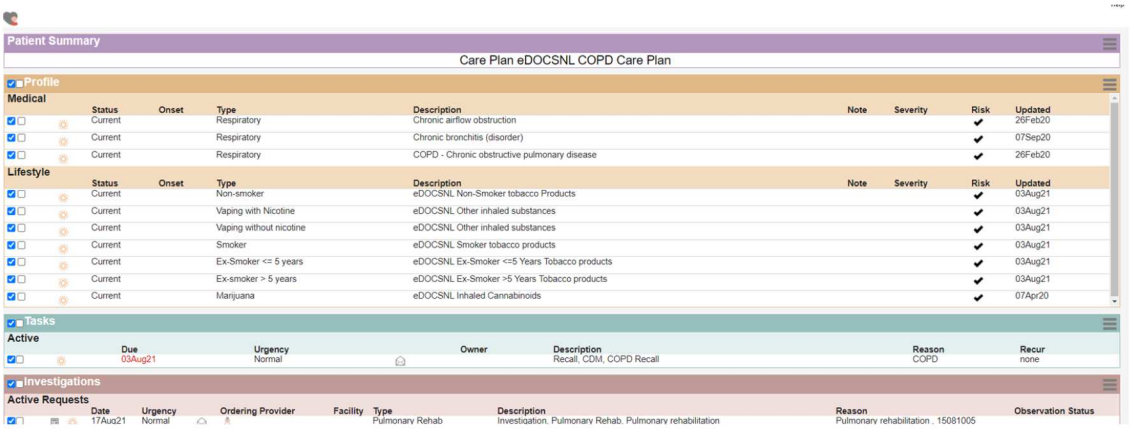

- Hello and welcome to the learning series for eDOCSNL Practice 360: COPD Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The COPD tools you will see today are the first of many chronic disease management tools that will be developed by the program in the coming months.
- eDOCSNL has partnered with provincial advisory groups and the Family practice renewal program on this development that aligns to the published COPD Clinical Practice Guidelines. This is a first of its kind initiative that Newfoundland and Labrador and our care providers are leading
- In this video we will introduce the components of the toolset and give you some idea as to why you might want to use them for the care and monitoring of the patients with COPD in your practice.
- Please keep in mind that all screenshots seen in this video are taken from a test system, so the content may not exactly reflect what you see in your own EMR but be assured the final product will be supported with all the necessary information to ensure you have absolute clarity and knowledge on how to use the toolset effectively in your practice.

# Accessing The eDOCSNL COPD Care Plan



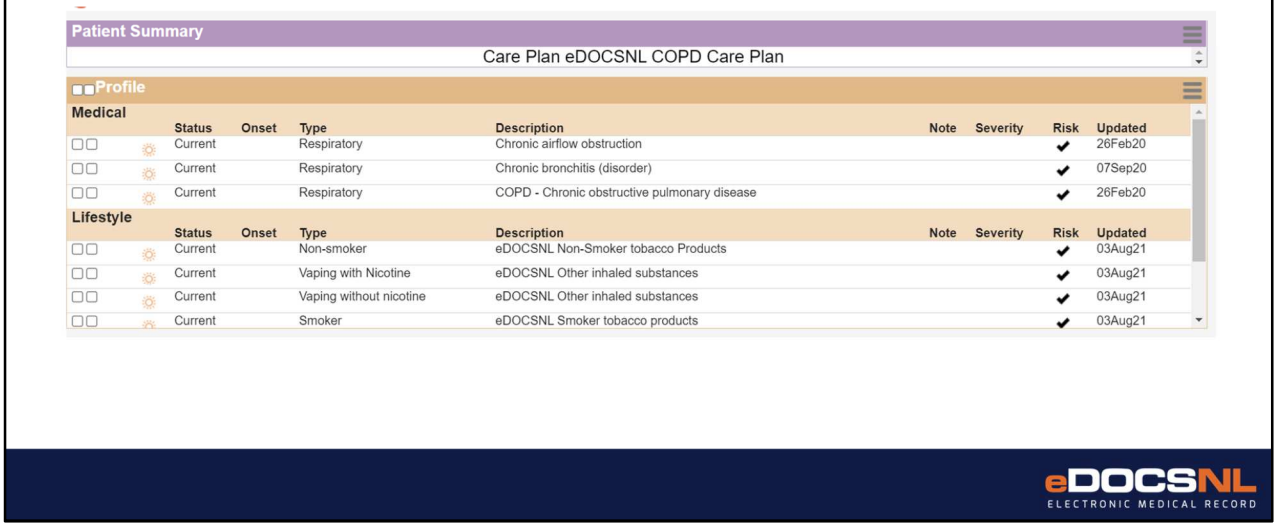

To access the COPD care plan hover over the “Care plan” icon in the visit and select the eDOCSNL COPD Care plan from the dropdown that appears

# The eDOCSNL COPD Care Plan



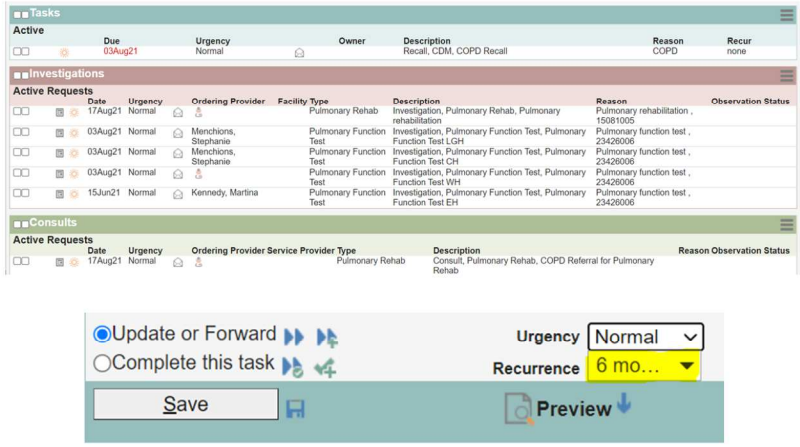

A care plan is a way to add multiple documentation items or perform multiple tasks simultaneously. This is an efficiency measure that prevents providers from having to navigate to multiple places in a chart to perform tasks one by one. It also enables you to set up recurrent tasks that support the Clinical Practice guidelines principles.
When the care plan first appears, all items are checked in blue on the left hand column as seen here.
These checkmarks indicated items that have been selected to apply to the current patient record.
Many of the items may not be applicable to apply to a given patient record so you will want to uncheck the items in bulk so that you can select only the items you want to apply.
This can be done by clicking the right box on the “Chart Summary” line at top left and then unchecking the same box.
The left box here would be clicked to “add details”, this is more applicable to the chart summary function and does not really apply here so do not check this box.

## Feature: Profile Items




The first section you will see in the care plan is the “Profile” area. Any item you check here will be applied to the patients profile when you apply the care plan.
There are may possible diagnoses here, we have tried to limit them to the items that might be applicable to patients living with COPD.
When items are added to the patient profile they will contribute information to the COPD dashboard and will enable other clinical decision support features.
Note that if you add something here that the patient already has in their profile, due to the functionality of the software a duplicate entry will be created.

## Feature: Recurrent Tasks

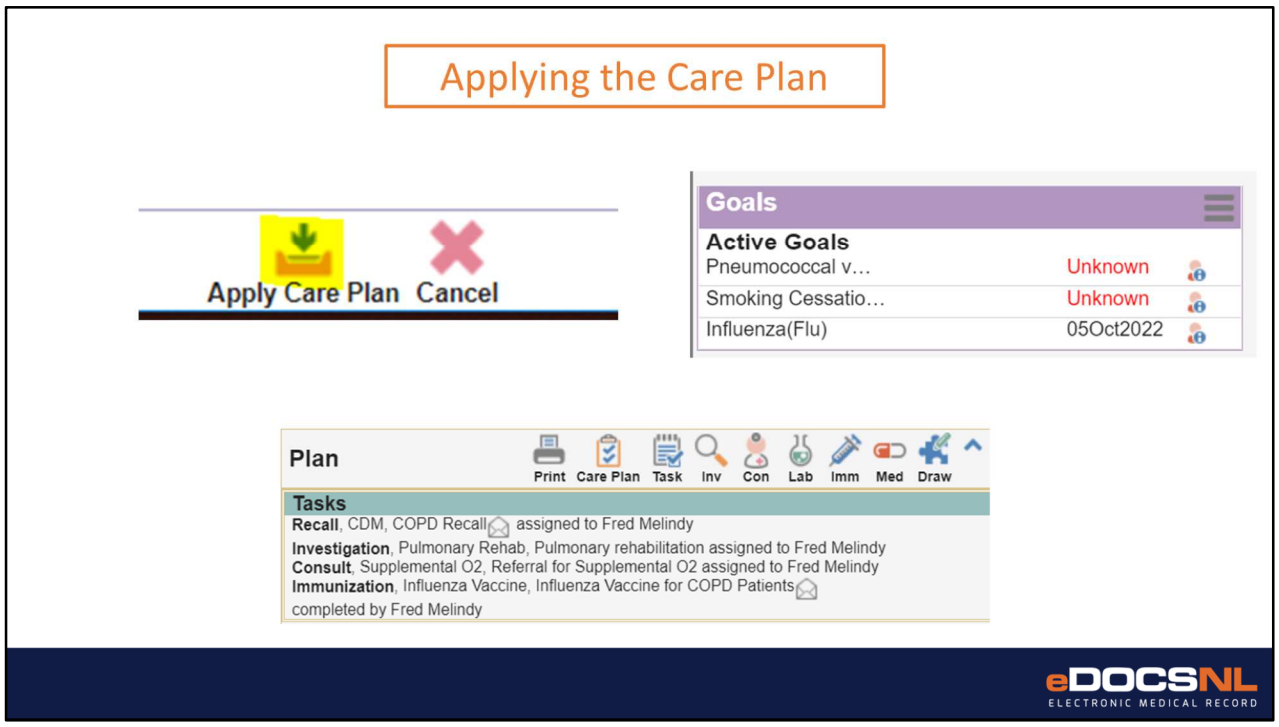



**TASKS:** You can add actions to be completed in the form of tasks to the patient visit from the care plan.
This is an efficiency measure so you don't have to order tasks one by one.
COPD care and monitoring is a continuous exercise so these tasks can be made to be recurrent according to your specifications. When you set up recurrent tasks from the care plan they will automatically appear in your inbox in the designated interval. In the example seen here the provider has selected to recall the patient for care and monitoring at 6 month intervals from within the recall task.
This will serve as a reminder to you that, as in the examples you see here, the patient needs to be seen again or has other elements of care and monitoring that need to be ordered on the interval specified by COPD guidelines

## Feature: Goals


eDOCSNL ELECTRONIC MEDICAL RECORD

**GOALS:** Patient goals can be set up from the care plan.
These goals are individualized to the particular elements of care and/or monitoring that you want to follow for this patient and have been configured to represent the critical elements of the COPD guidelines.
You do not have to select all the goals for any individual patient, though they are built to align with guidelines.
Select which goals you will apply to the individual patient by clicking the check box to the left of the individual item.
As you can see, satisfying the goals relies on standardized documentation practices and reinforce the use of the visit template. E.g. Smoking Cessation Advice

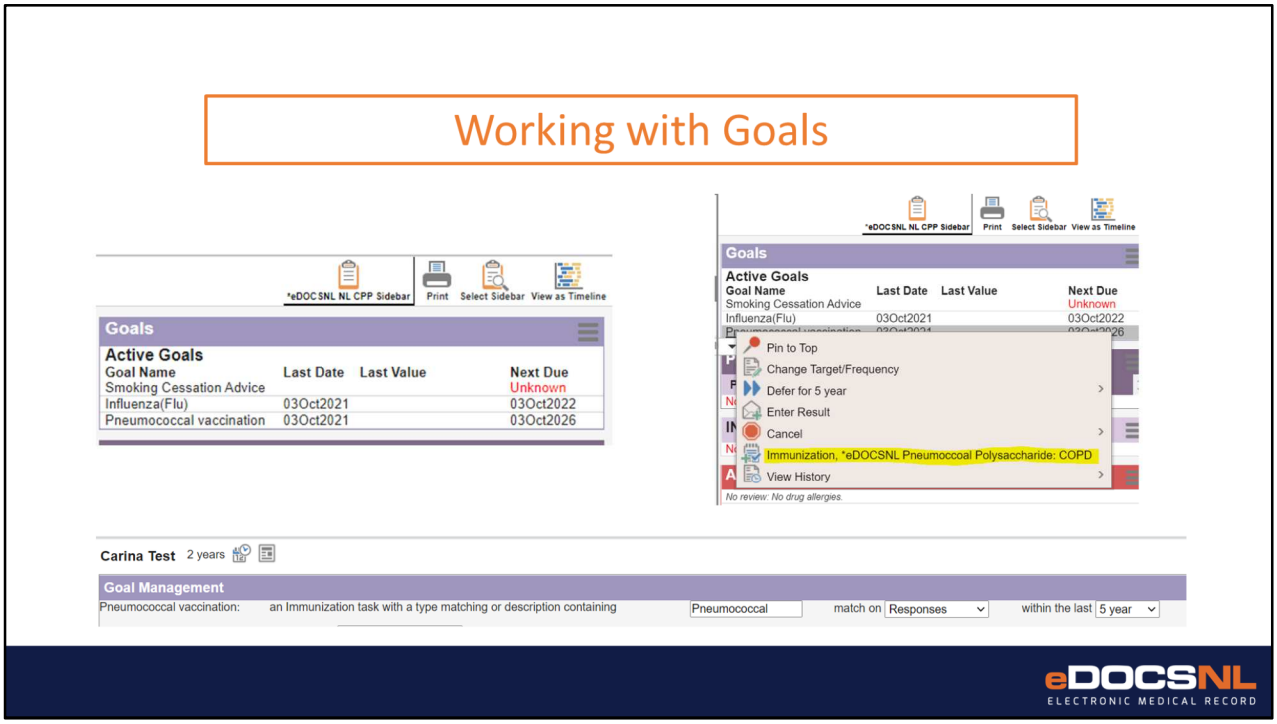



When you are finished selecting the elements of the care plan you wish to apply to the current patient, click the “Apply Care Plan” icon at the bottom of the care plan, you will then be returned to the patient visit view.

You will see in the “Plan” section, a summary of all the tasks that were ordered as a result of applying the care plan. You can action them individually from here.

Please note that these items are not completed or applied until they are actioned from this area.

Goals that were set up can be viewed from the sidebar view to the right of the patient visit template.



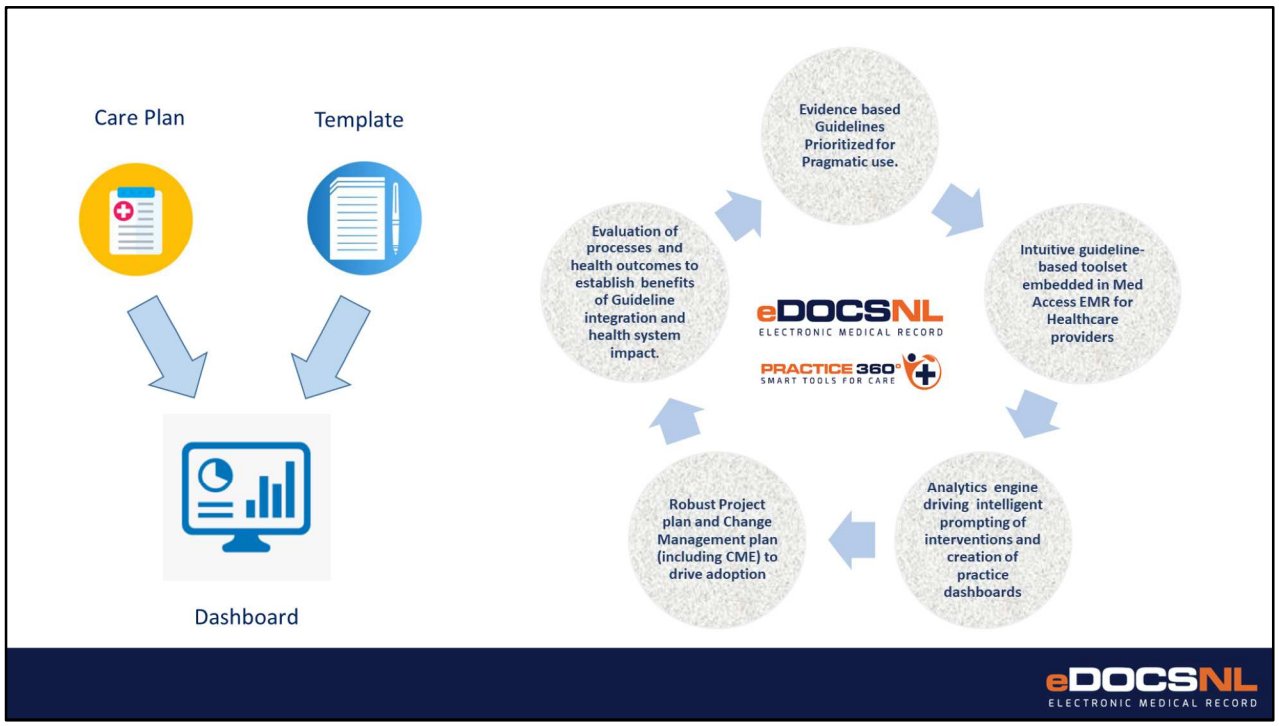

The goals are set up by default to reflect current recommendations in from the COPD guidelines but can be modified if indicated for a given patient.

Right clicking on the goal will produce a menu of options. From here, you can defer a goal to essentially skip a cycle, cancel a goal that you no longer wish to follow, manually enter a result for the value in question (if applicable), and complete the associated task to address the goal. In this example, we will select the Pneumococcal Vaccine goal and notice that you can complete the correct vaccination task directly from the goal itself.

Not all goals lend themselves well to this functionality so this is only applicable to some.

From the goals widget you can also select to change the target and/or frequency of a particular goal for an individual patient if indicated.

For example, if you decide that Pneumococcal vaccines should be given for this particular patient at a different interval than the goal currently specifies you simply select “Change Target/Frequency” from this menu and change the interval on the resulting goal set up window and save. The new goal will now indicate overdue only for the parameters that you set, with the caution that this patient is now being cared for individually rather than strictly according to guidelines.




The components of the toolset are mutually reinforcing.
The documentation template provides all the information to make point of care decisions while automating normally manual tasks, standardizes data input so that the software can enable other features providing clinical value and supports the creation of a data set for providers that can inform population level management.
The care plan populates chart information, patient goals and tasks in an efficient way that makes ongoing guidelines-based care and monitoring seamless.
The data generated by standardized documentation supported by the patient level tools and visit template informs the COPD dashboard and gives providers a population-level view of COPD in their practice.
This aligns with the eDOCSNL Practice 360 approach of using the intelligent and standardized features of the EMR to support and evaluate guidelines based care, presenting providers with the information they need for best practice decision making. Data provided by the EMR through the Practice 360 tools will enable the evaluation and refinement of guidelines and supports health system changes that will benefit patients living with COPD in Newfoundland and Labrador.

# Thank You



Contact us: info@edocsnl.ca

- Thank you reviewing this presentation on the Practice 360: COPD Toolset.
- Please reach out to the program at info@edocsnl.ca if you would like additional information or a focused session with program staff.